



**APPLICATION FOR LICENSE TO PRACTICE AS  
AN ANESTHESIOLOGIST'S ASSISTANT**

**NOTE:** Application must be fully completed with all requested information and documentation supplied. **\$300.00** application fee must accompany application; **application fee is non-refundable.**

I hereby make application to the State Board of Medical Examiners of South Carolina for an Anesthesiologist's Assistant license in the State of South Carolina and submit the following statement of facts with the required supporting documents. *The application form itself is a public document obtainable under the Freedom of Information Act.*

Applicant's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

Sponsoring Anesthesiologist: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

**I. EDUCATION**

1. List below all Anesthesiologist's Assistant schools attended and specific dates of attendance:

School	Location	From Mo./Day/Yr.	to Mo./Day/Yr.	Number Yrs. Attended
_____	_____	_____	_____	_____

2. Degree From: \_\_\_\_\_ Date: \_\_\_\_\_

3. Was your education interrupted, other than for vacation periods? \_\_\_\_\_ If yes, please attach a written explanation.

4. What is your certificate number from the National Commission on Certification of Anesthesiologist's Assistants, Inc.(NCCAA)?  
\_\_\_\_\_ Expiration Date: \_\_\_\_\_

5. Did you pass the first time you took it? \_\_\_\_\_ If no, how many times did you take it? \_\_\_\_\_

**Attach copies of diplomas, degrees, certificates of training and current NCCAA Certificate.**

## II. PERSONAL DATA

Answer Yes or No

1. Has your Anesthesiologist's Assistant license/certificate ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? \_\_\_\_\_
2. Have you ever had an application to practice as an Anesthesiologist's Assistant denied or refused by another licensing board or entity? \_\_\_\_\_
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? \_\_\_\_\_
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? \_\_\_\_\_
5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? \_\_\_\_\_
6. Is your Anesthesiologist's Assistant license/certificate currently restricted in any way by any licensing board or other entity? \_\_\_\_\_
7. Have you ever had a malpractice lawsuit, judgment or settlement filed against you?  
If so, how many? \_\_\_\_\_
8. Currently or within the last five years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as an Anesthesiologist's Assistant? \_\_\_\_\_
9. Has your ability to practice as an Anesthesiologist's Assistant ever been impaired by any physical or mental illness or by the use of alcohol or drugs? \_\_\_\_\_
10. Currently or within the last five years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as an Anesthesiologist's Assistant? \_\_\_\_\_
11. Have you ever discontinued practicing as an Anesthesiologist's Assistant for any reason for one month or more? \_\_\_\_\_
12. Currently or within the last ten years, have you ever been arrested, indicted or convicted, pled guilty, or pled nolo contendere for any violation of any federal, state or local law (other than minor traffic violations) \_\_\_\_\_
13. Have you ever been known by any other name or surname? \_\_\_\_\_
14. Have you ever voluntarily surrendered an Anesthesiologist's Assistant license/certificate? \_\_\_\_\_

**NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.**

### For Board Member Use only

\_\_\_\_\_  
Board Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

### III. EMPLOYMENT ACTIVITIES

List all activities chronologically since Anesthesiologist's Assistant training. Vacation periods and periods when you were not an Anesthesiologist's Assistant must be included. (Use additional sheets of paper as necessary.)

From (Mo./Yr.)	To (Mo./Yr.)	Office Address and Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all states in which you are or have been licensed/certified:

State	Date of Licensure/Certification	License/Certificate Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Military Service: Branch: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ Type of Discharge (attach copy) \_\_\_\_\_

### IV. LETTERS OF REFERENCE

Please list below names and addresses of three individuals willing to supply letters of recommendation to support your application for SC Anesthesiologist's Assistant licensure. Two of these three letters must be from physicians; the third may be from an Anesthesiologist's Assistant familiar with your work. You must request that these individuals write directly to this Board (on letterhead) indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for Anesthesiologist's Assistant licensure in South Carolina. Your application will not be considered complete until letters of reference from three individuals below and all other materials necessary to support your application have been received.

1. Name \_\_\_\_\_ Telephone (      ) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

2. Name \_\_\_\_\_ Telephone (      ) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

3. Name \_\_\_\_\_ Telephone (      ) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

## V. AFFIDAVIT

I, \_\_\_\_\_ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as an Anesthesiologist's Assistant in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as an Anesthesiologist's Assistant in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards, and to federal and state entities, as required by law.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public (L.S.) Notary Public for: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

***Please attach a copy of your written practice protocols. The Protocols must be signed by you and your sponsoring anesthesiologist.***

## AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this Affidavit of Eligibility. The information provided is subject to verification.

### **Section A: LAWFUL PRESENCE in the United States.**

I, (please print your full name) \_\_\_\_\_, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. \_\_\_\_ I am a United States citizen or legal permanent resident eighteen years of age or older; or
2. \_\_\_\_ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
  - a. \_\_\_\_ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
  - b. \_\_\_\_ I am a nonimmigrant under the "Immigration and Nationality Act,"  
Federal Public Law 82-414 as amended, eighteen years of age or older.
3. \_\_\_\_ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
  - a. \_\_\_\_ I am a US citizen, not physically present or employed in the United States.
  - b. \_\_\_\_ I am a Foreign National, not physically present or employed in the United States.

*If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.*

**Section B: Secure and Verifiable Document.** This section must be completed if you checked number 1 or 2 in Section A.

1. Please check the acceptable secure and verifiable document(s) you hold. A copy of the verifiable document(s) must be attached to the Affidavit of Eligibility.

- ☐ A valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card. Number \_\_\_\_\_; Date of Expiration: \_\_\_\_\_
- ☐ A valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit. State: \_\_\_\_\_; Number \_\_\_\_\_; Date of Expiration: \_\_\_\_\_.
- ☐ Permanent Resident Card; Alien Number \_\_\_\_\_; Card Number \_\_\_\_\_; Date of Expiration: \_\_\_\_\_.
- ☐ Employment Authorization Card; Alien Number \_\_\_\_\_; Card Number \_\_\_\_\_; Date of Expiration: \_\_\_\_\_
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Other: (Name of verifiable document) \_\_\_\_\_

2. Enter the state or the federal agency name where the secure and verifiable document(s) was issued.

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(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Include a copy of the card with the Affidavit)

**Section C: Attestation.**

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

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Signature

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Date

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Please print your name as shown on your secure and verifiable document.

Professional License Type: \_\_\_\_\_

License Number (if already licensed): \_\_\_\_\_

*The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.*

06/28/12 Affidavit of Eligibility

10/05/12 Revised

## VI. SPONSORING ANESTHESIOLOGIST

This information is to be completed by the Sponsoring Anesthesiologist:

1. Full Legal Name: \_\_\_\_\_ S.C. License No.: \_\_\_\_\_

2. Office Mailing Address: \_\_\_\_\_  
Street City State Zip

Office Phone #: ( ) \_\_\_\_\_

3. Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone #: ( ) \_\_\_\_\_

4. Type of Practice: \_\_\_\_\_

5. Are you a diplomat of the ABA? \_\_\_\_\_

6. List name and location of any hospital or other offices (other than your own) where you request this Anesthesiologist's Assistant to assist you:

Hospital/Office:

Location:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby certify that the foregoing is correct and true, and I assume responsibility for sponsoring my Anesthesiologist's Assistant and for ensuring that he/she is supervised by any other anesthesiologist, according to the approved written protocols for this Anesthesiologist's Assistant.

\_\_\_\_\_  
Supervising Sponsoring Signature

\_\_\_\_\_  
S.C. License No.

\_\_\_\_\_  
Date

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**Date Application Received:**

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**Committee Approval:**

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Date approved

THIS SPACE FOR OFFICE USE ONLY

Application for  
**ANESTHESIOLOGIST'S ASSISTANT**  
Licensure

Issued by the  
South Carolina Department of Labor, Licensing  
and Regulations  
Board of Medical Examiners  
110 Centerview Drive

Post Office Box 11289  
Columbia, South Carolina 29211  
(803) 896-4500

Interviewed/Approved by Board Member:

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Board Member/designee Signature

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Date approved

**IMPORTANT:** Applicant must bring all  
original diploma (s), licenses and NCCAA  
Certificate to the interview.

## PHOTOGRAPH

**Note:** A recent portrait type photograph  
must be pasted here. Photograph must be  
passport size or a snap shot.

(Please, no photo copies)

## GENERAL INFORMATION

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_



**South Carolina Department of Labor, Licensing and Regulation  
Board of Medical Examiners**

110 Centerview Drive  
P.O. Box 11289  
Columbia, South Carolina 29211  
(803) 896-4500  
Fax (803) 896-4515

Applicant's Name \_\_\_\_\_  
First Middle Last

I am applying for a license to practice as an Anesthesiologist's Assistant in South Carolina. Please complete this form bearing the institution's official seal to the address above.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**CERTIFICATION OF ANESTHESIOLOGIST'S ASSISTANT EDUCATION**

It is hereby certified that \_\_\_\_\_  
of (home town, state and country) \_\_\_\_\_  
attended (full name of program) \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_ and received a diploma  
conferring the degree of \_\_\_\_\_ and said diploma bears  
the following date \_\_\_\_\_.

(Seal)

\_\_\_\_\_  
(Dean, Registrar, AA Program Director)

Current Date \_\_\_\_\_

**South Carolina Department of Labor, Licensing and Regulation**  
**Board of Medical Examiners**  
110 Centerview Drive, P.O. Box 11289  
Columbia, South Carolina 29211  
(803) 896-4500  
Fax (803) 896-4515

**REQUIREMENTS FOR LICENSURE TO PRACTICE  
AS AN ANESTHESIOLOGIST'S ASSISTANT**

**I. REQUIREMENTS FOR LICENSURE:**

In order to qualify for licensure as an Anesthesiologist's Assistant, a completed application must be filed on forms provided by this Board.

The following requirements must be met (Section 40-47-1240):

- (A) successful completion of an accredited degree program for Anesthesiologist's Assistants;
- (B) current National Commission for Certification of Anesthesiologist's Assistant (NCCAA) certification.

**II. FEES: (Non-refundable)**

Total Application Fee = \$300

**III. APPLICATION FORM:**

The application form is self-explanatory. It sets forth the required supporting documents and/or information which must be submitted with your application.

An application will be considered incomplete until all of the following information is furnished:

- (A) all questions on the application answered fully; this includes the Affidavit of Eligibility
- (B) all supporting documents and/or information required by the application form received;
- (C) State certificates/licenses verified directly from the State Board of every state in which applicant is or has ever been certified/licensed ;
- (D) application fee submitted.
- (E) Certification of Anesthesiologist's Assistant Education
- (F) Verification of licensure from every state active or inactive
- (G) Practice protocol

**IV. REQUIRED INTERVIEW FOR LICENSURE:**

After the completed application is received in the Board Office and all criteria met, the Anesthesiologist's Assistant and sponsoring Anesthesiologist will receive a letter stating details about a personal interview with a Board Member or Board designee. Each applicant and sponsoring Anesthesiologist must meet with an assigned Board Member or designee before a license can be issued. *Original National Board Certificate, Anesthesiologist's Assistant training certificate and other relevant documents must be presented and verified during the interview. When the sponsoring Anesthesiologist receives a copy of the approved application from the Board, a copy of the Board's approval letter and approved protocol must be furnished, by the sponsoring Anesthesiologist, to all hospitals and other offices where the Anesthesiologist's Assistant will be working.*

**V. SUPERVISING PHYSICIAN AND SPONSORING PHYSICIAN**

Only an Anesthesiologist with a permanent SC medical license may serve as a supervising or sponsoring Anesthesiologist. A physician who is on probation with this Board may not serve as a sponsoring or supervising Anesthesiologist.

**VI. CHANGING SPONSORING PHYSICIAN/TERMINATING EMPLOYMENT**

If at any time employment is terminated or a change of sponsoring Anesthesiologist is requested, the Anesthesiologist's Assistant and sponsoring Anesthesiologist must notify the Board in writing, stating the reasons for termination. If changing sponsoring Anesthesiologist, a new application, along with a fee of \$25, must be submitted for Board approval. The interview process is the same as Section IV when changing a sponsoring Anesthesiologist.

**PLEASE NOTE:**

1. Do not make a mistake by underestimating the amount of time required to complete this application. Certification of AA education must be sent to your Anesthesiologist's Assistant training school and returned directly from your school to this Board.
2. It is a violation of the Medical Practice Act to practice as or be represented as an Anesthesiologist's Assistant before being licensed by this Board. Violators will be subjected to substantial penalties.

## Anesthesiologist's Assistant Verification

Complete the top portion of this form and forward a copy to each state board where you have held a license/certificate to practice as an Anesthesiologist's Assistant. You may want to contact each state to see if a fee is required.

### Verification of licensure

In applying for a license to practice as an Anesthesiologist's Assistant in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license/certificate. My signature below is your authority to release any and all information in your file, favorable or otherwise regarding myself, directly to:

**SC Dept. of Labor, Licensing and Regulation  
Board of Medical Examiners**

110 Centerview Drive  
P.O. Box 11289  
Columbia, SC 29211  
(803) 896-4500  
Fax (803) 896-4515

**PLEASE TYPE OF PRINT**

Signature \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

DO NOT DETACH

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**This section should be completed by an official of the state board and returned directly to the Board of Medical Examiners.**

Full name of licensee: \_\_\_\_\_

State of: \_\_\_\_\_ License/certificate number \_\_\_\_\_

Date issued: \_\_\_\_\_ Date expires: \_\_\_\_\_

License/certificate is current? \_\_\_\_\_ If no, why not? \_\_\_\_\_

Has license been suspended, revoked, or restricted? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Has licensee ever been required to appear before your Board? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Derogatory information, if any \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

(Board Seal)

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

(Please use reverse side for comments)

**South Carolina Department of Labor, Licensing and Regulation**  
**Board of Medical Examiners**  
110 Centerview Drive, P.O. Box 11289  
Columbia, SC 29211  
(803) 896-4500

**PRACTICE PROTOCOL FOR ANESTHESIOLOGIST'S ASSISTANTS (AA)**

As approved by the South Carolina Board of Medical Examiners, and the AA Committee of the Board, Anesthesiologist's Assistants may perform duties within written practice protocols and under the supervision of an anesthesiologist. Any duties not covered by the following must be individually considered and approved by the AA Committee and the Board before the AA may perform those duties.

1. There shall be at all times a direct, continual and close supervisory relationship between the AA and the supervising anesthesiologist, who shall at all times be responsible for the activities of the AA.
2. The AA shall provide delegated medical services within the scope of the education, training and experience of the AA. These services include gathering of preoperative data and perioperative patient evaluations, as well as delegated teaching and research functions, as appropriate.
3. Perioperative patient evaluation and care may include the following:
  - a. Administer anesthesia under the direction of the supervising anesthesiologist.
  - b. Initiate multiparameter monitoring prior to or during anesthesia or other acute care settings. The AA may use data from central venous, pulmonary artery and intracranial catheters as well as other monitors or devices that are indicated.
  - c. Manage pre and post anesthesia care, including ventilatory support of patients as assigned by the supervising anesthesiologist.
  - d. Initiate acute cardiopulmonary resuscitation in life threatening situations according to CPR/ACLS protocols.

Anesthesiologist's Assistant:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State & Zip

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Sponsoring Anesthesiologist:

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State & Zip

\_\_\_\_\_  
Signature

\_\_\_\_\_  
SC License #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date protocols developed

\_\_\_\_\_  
Date of annual review

\_\_\_\_\_  
Date protocols amended

## PRACTICE PROTOCOLS FOR ANESTHESIOLOGIST'S ASSISTANT

### Signature page for supervising anesthesiologists

*Anesthesiologists supervising an AA, must review the protocol submitted by the AA, and must sign below:*

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Practice Name

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Address

Supervising Anesthesiologist(s):

License #

Printed Name

Signature

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